Northwestern Medicine

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Telehealth Rooming Workflow

Purpose: To outline the workflow and standard information collected in preparation for a telehealth visit and should be used as a guide for practices while incorporating local standards.

1. Pre-Visit Prep (at time of scheduling or prior to visit)

- Patients may be asked to complete or gather information as applicable for the visit / specialty and access to the monitoring equipment. Examples include:
    - Height and weight
    - Blood pressure reading/logs
    - Blood sugar reading/logs
- Patients who may have had testing or procedures completed outside of NM should be asked to send copies to the practice to be available for telehealth visit:
    - Lab work (e.g., HbA1c)
    - Diagnostic Procedure (e.g., mammogram, colonoscopy)
    - Exams reports or dates (e.g., diabetic foot exam, retinopathy exam)
- Patients who are not active on MyChart should be asked to sign up and provided instructions on how to do so.

2. Initiating Telehealth Visit

- At the time of the scheduled visit, the clinical staff who is initiating the visit should access the patient's chart in EPIC, initiate contact with patient per practice standard, and verify patient's full name and date of birth.

3. Clinical Data Collection

Follow standard patient rooming workflow specific to the practice based on the needs of the visit type.

- **Chief Complaint**
    - Appointments scheduled in advance as a telehealth visit:
        - Enter the reason for visit in chief complaint section as appropriate and for needed smart sets to populate in EPIC (e.g., Well Child Visit, Allergy action plan, Asthma action plan, Medicare Visit)
    - Appointments converted into telehealth visits unexpectedly will require two (2) chief complaints documented:
        - "Telemedicine conversion" as first chief complaint
        - The reason for the visit is the second chief complaint
- Verify the patient's **Primary Care Provider**
- **Vital Signs**
    - Gathered per Physician/APP preference and based on home equipment available to the patient.
        - Weight, Height, blood pressure, pulse/heart rate, temperature, oxygen saturation if applicable
    - Documented in the vital signs in the "**Patient Reported Vitals**" section of the Rooming Activity. (Refer to Patient Reported Vital Signs tip sheet - https://home.ch.cadhlt.org/initiatives/epicproject/EpicTrainingWiki/_layouts/15/WopiFrame.aspx?sourcedoc=/initiatives/epicproject/EpicTrainingWiki/Shared%20Documents/Release%20Management%20Cycle/Patient%20Reported%20Vitals.pdf&action=default)

History

- Review the patient's social, medical, surgical, and family history per practice standard
  - Document tobacco use in social history
  - Identify and document any pertinent positives

- **Allergies**
  - Review current allergies on file
  - Add any new patient reported allergies
  - Reconcile outside allergies
- **Immunizations**
  - Review and update patient's immunizations as applicable to specialty
  - Reconcile outside immunizations
- **Medication Review**
  - Reconcile outside medications
  - Review the medication list in Epic with patient
    - Add any new medication name, dose, route, and frequency
    - Include any OTC, herbal remedies the patient is currently taking
  - Validate the patient's preferred pharmacy
  - Verify patient's prescription benefits if not already complete
  - Cue up and pend medication refills per Physician/ APP preference and practice protocol

4. Screening/ Best Practice Alerts (BPAs)

- Screenings - Complete per Physician/APP preference and practice protocols.
  Inform patient that the next question is sensitive and that they may need to be in a private area to answer
  - **Abuse screening** – every visit
    - Ask the first screening question of feeling physically and emotionally safe
      - Be sure to communicate positive results to Physician/APP
    - Signs of physical or emotional abuse/neglect present cannot be assessed over the phone and therefore should be left blank for telephone visit.
  - **Travel screening**
    - Indicate any positive COVID-19 results in last 40 days if not already completed
- Best Practice Alerts (BPAs)
  - Complete all relevant BPAs per practice protocol - **See Appendix A for details**

5. Handoff to Physician or APP

- Inform patient of next steps to their visit.
- Hand off to Physician/APP per practice standard
  - Notify physician/ APP of any pertinent positive results e.g. vital sign within critical range, positive screening results

Appendix A: Best Practice Alerts (BPA)

Best Practice Alerts (BPAs)

Address all BPAs per practice/specialty protocol:

1. **Depression screening (12yr +)**
   Inform patient that the next question is sensitive and that they may need to be in a private area to answer
   - Ask patient the screening PHQ2/PHQ9 questions as appropriate
   - Positive results should be communicated to the Physician/ APP per practice protocol.
     - Positive screening will also trigger a follow up BPA for physician/ APP.

2. **Influenza Vaccine (Sept 1- March 31) (6mo+)**
   - Inquire if patient received annual influenza vaccine
     - If vaccine was given externally, document in historical immunizations
     - If influenza vaccine was not given within the current flu season and the patient is a candidate offer options for administration (i.e., office visit, nurse visit, local pharmacy)

3. **Fall Risk Screening (65yr+)**
   - Ask the screening questions within the BPA
   - If the patients answers no to both screening questions listed in the BPA select “screen is negative” in the BPA.
   - If a patient screens positive, follow your practice protocol for follow up (e.g. notify physician and/or create reminder to complete TUG test at next in person visit). A positive screening may also trigger a follow up BPA for physician/ APP

4. **Diabetes Related BPAs:**
   - HbA1c
     - Ask the patient if an external HbA1c test was completed
     - If yes, enter results per practice protocol
     - If no, notify MD/APP to address during visit
   - Diabetic Eye (Retinal) Exam
     - Ask the patient if a diabetic eye exam was completed
     - If yes, enter results per practice protocol
     - If no, notify MD/APP to address during visit
   - Diabetic Foot Exam
     - If foot exam is overdue notify MD/APP to address during visit
5. **Colorectal Cancer Screening (50yr – 75yr)**
   - Ask patient the date of last colon cancer screening (Colonoscopy, Cologuard, I-FOBT)
     - If colonoscopy completed externally, open Colonoscopy SmartForm and enter results, recommended interval if known, and other details per practice protocol
     - If Cologuard or I-FOBT completed externally, add HM modifier for this testing and document in Health Maintenance
     - Request patient send copy of results to practice if needed
   - If colorectal cancer screening is overdue notify MD/APP to address during visit
6. **Breast Cancer Screening (50yr – 74yr)**
   - Ask patient date of last mammogram

  - Document date in record if needed
  - Request patient send copy of results to practice if needed
- If breast cancer screening is overdue notify MD/APP to address during visit

7. **Pneumococcal Vaccine (65yr+)**
   - Inquire if patient received pneumococcal vaccine outside of NM
     - If vaccine was given externally, document in historical immunizations
     - If vaccine has not given and the patient is a candidate offer options for administration (i.e., office visit, nurse visit, local pharmacy)
8. **Tobacco Cessation (18yr – 85yr)**
   - Complete the tobacco use section in social history

Appendix B: Scope of Practice - Rooming Responsibilities and Quality Metrics

Rooming Responsibilities	In-person Visit	Telehealth Visit	In Scope for MA/LPN	In Scope for PSR/PL	In Scope for RN
Chief Complaint	X	X	Yes	No	Yes
Vital Signs • **Ht/Wt** • **BP** • **HR** • **RR** • **SaO2**	• Ht/Wt - X • BP - X • HR - X • RR - X • SaO2 -X	• Ht/Wt - X* • BP - X* • HR - X* • RR • SaO2 - X*	Yes	No	Yes
Allergies/ Contraindications	X	X	Yes	No	Yes
Verify PCP	X	X	Yes	Yes	Yes
Verify Preferred Pharmacy	X	X	Yes	No	Yes
Medications • **Taking/Not Taking**	X	X**	Yes	No	Yes
Outside Med Reconciliation	X	X**	Yes	No	Yes
History	X	X	Yes	No	Yes
Tobacco Screening (included in social history)	X	X	Yes	No	Yes
BPA – Depression (PHQ2)	X	X	Yes	No	Yes
BPA – Influenza	X	X***	Yes	No	Yes
BPA – Hemoglobin A1C	X	X	Yes	No	Yes Plus Diabetes Education

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Diabetic Eye Exam	X	X	Yes	Yes *Scan external results only	Yes
Screening: Breast Cancer	X	X	Yes	Yes *Scan external records only	Yes
Screening: Colorectal Cancer	X	X	Yes	Yes *Scan external records only	Yes
Screening: Fall Risk	X	X	Yes	No	Yes
Pneumonia Vaccination	X	X***	Yes	Yes *Scan external records only	Yes

* Patient reported values, if patient has equipment to measure at home

**May be difficult to confirm if not able to “show” medication name to patients

***Can complete BPA but cannot complete action (e.g., give vaccine)